Local Enhanced Service

Intra-uterine contraceptive device fittings

Introduction

1. All practices are expected to provide essential and those additional services they are contracted to provide to all their patients. This enhanced service specification outlines the more specialised services to be provided. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

Background

2. Evidence shows that:

(i) IUCDs make up approximately 5 per cent of contraceptive usage in the UK[1]. This is much lower than in many other European countries. In Scandinavia, IUDs make up 20% of contraceptive usage[2]

(ii) clinical effectiveness is excellent, with a recognised failure rate for all devices of 0.2-2.0 per 100 woman-years. For the levonorgestrel-releasing intrauterine system (LNG-IUS) the failure rate is 0.16/100 woman-years which is comparable to female sterilisation[3]

(iii) it is one of two areas of contraceptive provision with relatively high levels of litigation and the most important factor influencing failure rate and problems is the competence of the professional inserting the device.[5]

(iv) the risk of pelvic inflammatory disease attributable to IUCD usage is low at 1.5. [6] 1000 women have an IUCD inserted, then 1.5 of them will develop pelvic inflammatory disease

(v) the World Health Organisation (WHO) supports the use of the IUCD in young women including those under 20 years provided they are at low risk of sexually transmitted infections (STI)[7]

(vi) the LNG-IUS has additional non-contraceptive benefits of decreasing menstrual loss and is part of the management of menorrhagia recommended by the Royal College of Obstetricians and Gynaecologists (RCOG)[8]

(vii) insertion of a copper IUCD up to 5 days after presumed ovulation acts as a very efficient emergency post-coital contraception. Because of its increased post-coital time frame and non hormonal constituents, it is complementary to the emergency use of the progesterone-only contraceptive pill

(viii) IUCD fitting is not undertaken by all general medical practitioners and maintaining expertise in IUCD fitting can be difficult.[9]

Aims

3. The aims of this service are to:

- ensure that the full range of contraceptive options is provided by practices to patients
- ensure that the availability of post-coital IUCD fitting for emergency contraception should be more adequately provided as another means of reducing unwanted pregnancies
- increase the availability of LNG-IUS in the management of menorrhagia within primary care.

Service outline

4. This local enhanced service will fund:

- **fitting, monitoring, checking and removal of IUCDs** as appropriate

- **production of an up-to-date register of patients fitted with an IUCD.** This will include all patients fitted with an IUCD and the device fitted. This is to be used for audit purposes, and to enable the primary care team to target these patients for health care checks

- **insertion of Implanon Hormone Implants**

- **practices to undertake regular continual professional development (CPD)**

- **provision of adequate equipment**. Certain special equipment is required for IUCD fitting. This includes an appropriate room fitted with a couch and with adequate space and equipment for rescuscitation. A variety of vaginal specula, cervical dilators, and equipment for cervical anaesthesia also need to be available. An appropriately trained nurse also needs to be present to support the patient and assist the doctor during the procedure
- **chlamydia screening** before insertion of the IUCD and, if positive, refer for screening for other STIs. This should be in accordance with national policy, or with PCO policy if there is no relevant national policy

- **the use of condoms to prevent infection**

- **regular assessment**. A check of the IUCD after fitting is suggested at six weeks and thereafter annually. In addition any problems such as abnormal bleeding or pain should be assessed urgently

- **provision of information.** Written information should be provided at the time of counselling and reinforced after fitting with information on follow-up and those symptoms that require urgent assessment

- **production of an appropriate GP record.** Adequate recording should be made regarding the patient's clinical history, the counselling process, the results of any chlamydia screening, the pelvic examination, problems with insertion, the type and batch number of the IUCD, and follow-up arrangements. If the patient is not registered with the practice providing the LES, the providing-practice must ensure that the patient's registered practice is given all appropriate clinical details for inclusion into the patient's notes

- **the use of LNG-IUS for the management of menorrhagia in primary care as part of a care pathway agreed and developed with local gynaecology departments.** To ensure these devices are used for the correct patients and the approved indications

- **an annual review**, which could include an audit of:

  (a) the register of patients fitted with an IUCD
  (b) continuous usage rates
  (c) reasons for removal
  (d) complications.

- **Practices may contract to undertake coil annual review only**

Accreditation

5. Practitioners undertaking this procedure should have undertake appropriate training. This should be based on modern, authoritative medical opinion, for example, the current requirements set down by the Faculty of Family Planning and Reproductive Health Care (FFPRHC) for the letter of competence in intrauterine techniques (LoC IUT). This involves a demonstration of gynaecological skills in assessing the pelvic organs, a minimum number of ten observed insertions in conscious patients, and appropriate knowledge of issues relevant to IUCD use, including counselling.

6. Those doctors who have previously provided services similar to the proposed enhanced service and who satisfy at appraisal and revalidation that they have such continuing medical experience, training and competence as is necessary to enable them to contract for the enhanced service shall be deemed professionally qualified to do so.